

EXHIBIT 4

Employer Statement
(Confirmation of Election requiring Evidence of Insurability)

Tyco International (US)
Hartford Policy # GL-206835

October 25, 2002

RICHARD G WILKINSON
135 LOUISE STREET
WOONSOCKET, RI 02895

ADP97 Y7X FLVCAM4 3 25

Employee Social Security Number: [REDACTED]

Employee Date of Birth: [REDACTED]
[REDACTED] Sep 17, 1973

Requested Coverage

Employee Requested Supplemental Life Coverage: 1 x Annual Salary, \$57,000
Guaranteed Issue Amount: \$0
Basic Life Amount: 1 X Salary

Please complete the Hartford Life "Personal Health Statement" for Supplemental Life Insurance enclosed with this package and mail the form and this form together to:

HARTFORD LIFE
GROUP MEDICAL UNDERWRITING
PO BOX 2999
HARTFORD, CT 06104-2999

Coverage other than the guaranteed issue amounts listed on this form must be approved by the carrier before coverage becomes effective.

This Employer Statement must be attached to your completed Hartford Life Personal Health Statement and mailed directly to the above insurance company.



PERSONAL HEALTH STATEMENT

Employees must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to show evidence of good health.

For questions about how to complete this form, call Hartford Life at

1-800-331-7234

Instructions

1. Make sure the "Employer Statement" outlining the coverages being requested is included with this form when submitted to Hartford Life.
2. Answer all questions completely and accurately. Even seemingly minor details like height and weight are very important and must be accurate. Forms with unanswered questions will be returned to you to complete and will delay the review process.
3. Understand that an employee who has enrolled as a "Late Entrant" is responsible to pay for the cost of physical exams or medical tests if they are required now or are requested during the application process.
4. You, the employee, must always sign this form regardless of the coverage requested. Your spouse/domestic partner must sign the form only if requesting coverage. All signatures must be full legal names, and all forms must be dated. Forms must be received by The Hartford within 30 days of that signature date.
5. This Personal Health Statement and the "Employer Statement" must be received by The Hartford no later than 45 days from the date of the "Employer Statement". The "Employer Statement" indicates which enrollees need to be listed on the Personal Health Statement. Please be sure to answer all questions for all applicants who need to complete this form. The information on the form will be considered "current" for not more than 90 days. That is why it is important to fill out the form completely and include the "Employer Statement". Leaving information blank will cause delays and can even result in your request being closed.
6. Upon completion:
 - SEND BOTH THE EMPLOYER STATEMENT AND THE COMPLETED FORM – TO:
Hartford Life
Group Medical Underwriting
(Address is noted on the Employer Statement)
 - Keep a copy of the completed forms for your records.

Coverages underwritten by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company

The Employer Statement recording your benefit elections supplied with this form must be attached and sent to Hartford Life.

Coverage is available to you only if you continue to be an eligible employee, or employee's lawful spouse or eligible domestic partner.

Coverages underwritten by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company.

Employee Section **Personal Health Statement** **BEFORE MAILING**
Case print in dark ink. Initial any change. Case 1:04-cv-00516-ML Document 33-5 Filed 06/07/2005 Page 4 of 5
Employer Name Tyco International (US) Inc. Policy Number GL-206835
Employee Name - First Name _____ MI _____ Last Name _____
Billing Address _____
City _____ State _____ ZIP _____
Social Security Number _____ Occupation _____
Mail _____ Phone Number _____ Work: _____ Home: _____

Check that all questions are answered, form is dated and signed.
• Keep a copy for your records.

Enrollees Requiring Health Information
List below the names of enrollees identified on the Employer Statement.

First Name, MI, Last Name	HEIGHT (ft/in) Required	WEIGHT (lbs) Required	DATE OF BIRTH	GENDER M F
Employee	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Spouse/Domestic partner	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Questions 1-24 are to be answered collectively by all Enrollees listed above; i.e. if any one Enrollee answers Yes to a question, mark the [Y] answer. Otherwise, mark [N] for No. For all Yes answers, provide additional details below.

During the past 10 years have you:

Had surgery or been told to have surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	3. Had any injuries from a car accident, or filed a Worker's Compensation claim?	<input type="checkbox"/> Y <input type="checkbox"/> N	5. Consulted or been examined by any doctor or other medical practitioner other than normal physical exams or acute illness such as cold, flu, or sore throat?	<input type="checkbox"/> Y <input type="checkbox"/> N
Been in a hospital or other institution for diagnosis or treatment	<input type="checkbox"/> Y <input type="checkbox"/> N	4. Been declined for any life or disability insurance coverage?	<input type="checkbox"/> Y <input type="checkbox"/> N	6. Had any lab tests, x-ray, electrocardiogram or other diagnostic testing other than those requested as part of routine physical with normal findings?	<input type="checkbox"/> Y <input type="checkbox"/> N

During the past 10 years have you at any time been treated or told you had a problem with any of the following:

7. Heart, chest pain, abnormal pulse, high blood pressure, stroke, heart murmur blood or circulatory, or vascular conditions?	<input type="checkbox"/> Y <input type="checkbox"/> N	14. Genital or reproductive organ problems?	<input type="checkbox"/> Y <input type="checkbox"/> N	21. "AIDS," AIDS-related complex, or been tested positive for the antibodies to the AIDS virus, or do you have enlarged lymph nodes or unexplained weight loss?	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Cancer or tumors, or leukemia?	<input type="checkbox"/> Y <input type="checkbox"/> N	15. Drug or alcohol abuse, or used alcohol or nicotine on a regular basis? Indicate amount used daily.	<input type="checkbox"/> Y <input type="checkbox"/> N	22. Are you pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Diabetes, thyroid, liver, glands, or spleen?	<input type="checkbox"/> Y <input type="checkbox"/> N	16. Eyes, ears, nose or throat?	<input type="checkbox"/> Y <input type="checkbox"/> N	23. Are you taking any medication for any condition or disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Asthma, bronchitis, allergies, pneumonia, or respiratory problems?	<input type="checkbox"/> Y <input type="checkbox"/> N	17. Psychiatric, mental, nervous disorders, including depression?	<input type="checkbox"/> Y <input type="checkbox"/> N	Important:	
11. Ulcers, stomach, rectum, intestines, Gallbladder, upper or lower digestive system?	<input type="checkbox"/> Y <input type="checkbox"/> N	18. Back, spine, bones, muscles, connective tissue, ligaments, tendons or joints?	<input type="checkbox"/> Y <input type="checkbox"/> N	24. Any symptoms, injury, birth defect congenital defect, disease or disorder not mentioned above?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Arthritis or Rheumatism?	<input type="checkbox"/> Y <input type="checkbox"/> N	19. Immune system, anemia or other blood conditions?	<input type="checkbox"/> Y <input type="checkbox"/> N		
13. Kidneys, bladder or urinary tract?	<input type="checkbox"/> Y <input type="checkbox"/> N	20. Brain or nervous system problems, or epilepsy?	<input type="checkbox"/> Y <input type="checkbox"/> N		

Notice: Enrollee is required to notify Hartford in writing of any changes in the applicant's medical condition between the date the applicant signs this form and the date coverage is approved.

FOR EACH 'YES' ANSWER ABOVE, IDENTIFY THE QUESTION NUMBER, APPLICANT NAME AND PROVIDE DETAILS REQUESTED.

Question No.	Applicant Name	Medical Condition	Date Sought Treatment	Duration of Condition	Treatment
Current Status	Physician's Name, Street, City, State and Zip Code				
Question No.	Applicant Name	Medical Condition	Date Sought Treatment	Duration of Condition	Treatment
Current Status	Physician's Name, Street, City, State and Zip Code				
Question No.	Applicant Name	Medical Condition	Date Sought Treatment	Duration of Condition	Treatment
Current Status	Physician's Name, Street, City, State and Zip Code				

If additional space is required, please attach a separate sheet. Sign and date each sheet.

Important: See reverse side. Your signature indicates that you have read this important information.

BOTH THE EMPLOYER STATEMENT AND EMPLOYEE SECTION OF THIS FORM MUST BE RECEIVED BY HARTFORD LIFE WITHIN 30 DAYS OF THE SIGNATURE DATE. ITS INFORMATION WILL BE CONSIDERED CURRENT FOR NO LONGER THAN 90 DAYS FROM THE SIGNATURE DATE.

I hereby certify that the above statements and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statements and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. This information may be used by the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company (for fully insured coverages) or y employer/administrator (for self-funded coverages), to decide if the person(s) is eligible for coverage.

I authorize any physician, medical or health practitioner, counselor, therapist, hospital, clinic, or other medical or medically-related facility, insurance or reinsurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer that has records or knowledge of me or my health or my children or their health to give the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its legal representative, any non-medical information or medical information that relates to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries or any other health conditions; 2) Confinements in hospitals, medical facilities or medical clinics; 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners; 4) Drug abuse, alcohol abuse, or mental health protected by Federal Law; 5) Counseling or therapy for the purpose of determining eligibility for insurance or eligibility for benefits under an existing policy. This information will be treated as confidential. I acknowledge that I have read all the information on the reverse side of this page.

EMPLOYEE'S SIGNATURE (required)	DATE SIGNED	SPOUSE'S SIGNATURE (required only if applying for coverage)	DATE SIGNED
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I authorize the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company to release information in its file to the Medical Information Bureau, Inc. and other insurance companies to whom I may apply for Life or Health Insurance, or persons or organizations, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, old or transferred to any person without first obtaining my consent on a written form stating the use and need for such information.

I understand that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself in connection with this application.

I understand that if I request details about any medical record information, collected about myself in connection with this application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I understand that upon written request, I may revoke this authorization except to the extent that action has already been taken in reliance on the consent.

I understand that this authorization will expire two years from the date of the policy or that this authorization will expire one year from the date of signature, if no policy has yet been issued.

I understand that a photographic copy of this authorization shall be as valid as the original.

I understand that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage under this plan as of the effective date.

MEDICAL UNDERWRITING DISCLOSURE FORMAT

The following summary of information practices is being provided in accordance with our policy on privacy.

Collection of Information

In order to properly underwrite your request for group benefits, we must collect certain information about your physical condition.

You are the most important source of information about your own health, and to the degree it is possible, we will rely on only information obtained from you. If we do find we are required to contact medical professionals or institutions, we will contact them directly using the authorization on the front side of this form.

Disclosure

Information we collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people who have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, we will ask you for written authorization to disclose information about you.

Access and Consent

In most cases the only information we will collect is provided by you. You are encouraged to keep a copy of this form for your records. If we find it is necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which we have collected. Upon written request, we will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to us. Details regarding your right to correct or amend information in your file will be furnished upon written request.

We hope you find this summary helpful. If you have any further questions about privacy policy and practices, please write to:

HARTFORD LIFE
Group Medical Underwriting
(Address is noted on the Employer Statement)

We take our responsibilities in handling your personal information very seriously.